STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 02/09/2012	
	PROVIDER OR SUPPLIE NA HEALTH AND F	REHABILITATION CENTER	1420 E	DOUGLAS RD WAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
F0000	(PSR) to the Relationary Licensure Survey December 12, 2 Survey Dates: 12 Facility Number Provider Number AIM number: 2 Survey Team: Vicki Manuwal Bobbie Costigates Susan Bruck, Relationary Census bed types SNF: 27 SNF/NF: 47 Total: 74 Census payor type Medicare: 30 Medicaid: 28 Other: 16 Total: 74 Sample: 9	February 6, 7, 8, and 9, r: 012329 er: 155784 201002500 , RN-TC n, RN N e:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

012329

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155784	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 02/09	LETED
MICHIAN	ROVIDER OR SUPPLIER A HEALTH AND REHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	cited in accordance with 410 IAC 16.2.				
	Quality review completed 2/15/12 Cathy Emswiller RN				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO.	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155784	A. BUILD	ING	00	02/09/	
		1557 64	B. WING			02/09/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER			DOUGLAS RD VAKA, IN 46545		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157 SS=D	resident; consult and if known, not representative or member when the the resident which the potential for rintervention; a significantly (i.e., existing form of the consequences, confereatment); or discharge the resident and, if known there is a cassignment as span change in resident.	NE/ROOM, ETC) Imediately inform the with the resident's physician; tify the resident's legal an interested family ere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, status in either life itions or clinical a need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 3.12(a). also promptly notify the nown, the resident's legal interested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in					
	update the addre	record and periodically ess and phone number of the epresentative or interested					
	facility failed to physician of alter requiring treatme	ew and record review, the notify a resident's ration in skin integrity ent for 1 of 4 residents eviewed with skin issues	F015 ²	7	It is the practice of this facilit to notify resident's physician and legal representative or ar interested family member of accidents resulting in injury.		02/29/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155784	B. WIN	G		02/09/2012
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
TAG	in a sample of 9. Findings include The clinical recoreviewed on 2/6/ Resident # 17's dwere not limited congestive heart fibrillation. During initial total A.M., LPN # 3 is having a skin teated a skin teated a skin teated total tota	rd for Resident # 17 12 at 11:55 A.M. liagnoses included, but to: hypertension, failure, and atrial ar on 2/6/12 at 10:10 dentified Resident # 17 as r on the left elbow. ccident/Incident Report" dicated, "during med s found bandage on res) arm c (with) Allyven) et (and) Kerlix (type of kin tear) 2.5 cm x .5 cm notified. Stated they were sed. Happened during yPhysician ogress Notes" dated d, "Skin on left forearm transfer from bed to		TAG	CORRECTIVE ACTION: Resident #17's physician was notified and treatment obtained for skin tear. HOW OTHERS IDENTIFIED: 1 time review of in-house residents will be completed to ensure physician notification ppolicy with any accident/incide PREVENTATIVE MEASURES Communication form to be use to enusre that any accident/incident occuring in therapy is communicated appropriately to nursing staff. Re-education of nursing and therapy staff in regards to propreporting with any accident/incident will be completed. MONITORING: DON/Designe and Therapy designee to mee Monday through Friday to reviany communication forms. Results will be forwarded to facility Quality Assurance for further review and recommednations as deemed appropriate. Identified non-compliance will result in 1 re-education with progressive disciplinary actions per policy to and incuding termination. T process will be indefinite.	d A er er ent. : ed Der :1
	indicated, "Ski	n on her left forearm was transfer from bed to			COMPLETION DATE: 2/29/12	2

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/09/2012	
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	32/03/2012
	PROVIDER OR SUPPLIEF		1420 E	DOUGLAS RD	
(X4) ID		EHABILITATION CENTER TATEMENT OF DEFICIENCIES	ID ID	WAKA, IN 46545 1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	good with her	therapists were very			
	Statement" dated noticed wound on notified nurse witherapy. This the (patient) on Fridany injury. Pt with by 2 therapist in family members A second "Wither Statement" dated "Date of Incide (L UE) (left uppunknown origin, draining on gowidressing & Kling				
	Review of a Phy 1/25/12, indicate elbow c N.S. (no apply bacitracin, Kerlix q (every) until healed" During interview at 12:10 P.M., sl	sician Order, dated ed, "Cleanse area to L ormal saline) pat dry, cover c telfa wrap c day & prn (as needed) with LPN # 5 on 2/6/12 he indicated Resident # 17 he tear with therapy during			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPL 02/09/	ETED
	PROVIDER OR SUPPLIER NA HEALTH AND REHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CO DOUGLAS RD WAKA, IN 46545	DDE .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	LPN # 5 on 2/6/12 at 3:15 P.M., during interview indicated she and LPN # 6 discovered the skin tear already dressed and covered when they went in to check on the resident between 1st and 2nd shift. She further indicated therapy did not advise the nursing staff of the skin tear occurrence. During interview with the DON on 2/7/12 at 10:45 A.M., she indicated the therapist who dressed Resident # 17's skin tear is actually a wound specialist. She further indicated the therapist still should have reported the skin tear to the nurse. During interview with the Therapy Supervisor on 2/7/12 at 2:55 P.M., he indicated the therapist who dressed the skin tear told him there was no nurse available to report the skin tear to so she dressed it and went on with her day. He further indicated this was not how the situation should have been handled. The therapist failed to report the injury to nursing staff so they could contact the appropriate parties. He further indicated he inserviced the entire therapy staff regarding the proper way to communicate such situations to the nursing staff. The clinical record indicated Resident # 17's physician was not notified of the incident until 1/21/12 after LPN # 5				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155784	A. BUILDING B. WING		02/09/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER		DOUGLAS RD WAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	discovered the sl	kin tear. The clinical dicated the incident 1/12.	TAG	DEFICIENCY)	DATE

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/09/2012
	ROVIDER OR SUPPLIER	L EHABILITATION CENTER	STREET 1420 E	ADDRESS, CITY, STATE, ZIP CODE E DOUGLAS RD WAKA, IN 46545	3
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE	D BE COMPLETION
F0282 SS=D	CARE PLAN The services pro facility must be p	QUALIFIED PERSONS/PER vided or arranged by the provided by qualified persons ith each resident's written	F0282	It is the practice of this f	acility 02/29/2012
			F0282	It is the practice of this fat that the services provide arranged by the facility a proivded by quailifed per in accordance with each resident's written care plead CORRECTIVE ACTION: 43's oxygen is being admin per physician's order. Reserveciving medication per physician's order. HOW OF IDENTIFIED: Audit of all resident's with orders for to ensure that physician's being followed related to reflow. MAR's audited to enthat documentation related are not given have proper documentation an administ per parameters as applicable. PREVENTATI MEASURES: Directed Info all nursing staff on Polici Procedure on Medication Administration and followin Physican Orders will be completed. DON/Designed complete documented more for residents with orders for Oxygen to ensure that the flow is per physician's ord MAR's will be monitored to ensure proper documentation well as following parameters.	re rsons lan. Res# inistered s# 26 is THER Dxygen order is ate of asure d that stered IVE -service cy and or erate of er and or on as

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION		A. BUILDING	00		LETED
		155784	B. WING		02/09)/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
MICHIAN		REHABILITATION CENTER		DOUGLAS RD WAKA, IN 46545		
				T 40040		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N RE	(X5)
TAG	·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION DATE
TAG	Based on observer record review, the physician orders oxygen administ (Resident # 43) and failed to followed to medic 9 residents review (Resident #26) in Findings included 1. A clinical recompleted for R at 3:25 p.m. Resident Resident Recompleted for R at 3:25 p.m. Recomplete	vation, interview, and he facility failed to ensure s were followed for tration for 1 of 3 residents reviewed with oxygen, low physician orders ation parameters for 1 of ewed for parameters in a sample of 9.	TAG	physician ordered medications. MONITORIN DON and/or designee will reverse of the veeks, then 3 times per week for 4 weeks, then we 16 weeks, then monthly for months. March 12, 2012 Addendum: All residents woxygen will be monitored be DON or designee and will all shifts. The MAR's will be monitored per the same so as the Oxygen. Results with forwarded to facility Quality Assurance for further revier recomedations as deemed appropriate. Indentified non-compliance will result is re-education with progress disciplinary actions per polito and including termination.	nonitor s daily er ekly for 2 with y the cover e hedule ll be w and n 1:1 ve cy up	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULT A. BUILDII B. WING		nstruction 00	(X3) DATE (COMPL 02/09 /	ETED	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	1	420 E [DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(Chronic Obstru Disease), hypox (hypertension).	active Pulmonary ia, and HTN					
	Record) for Feb "O2 1L/NC (1	lication Administration ruary 2012 indicated, liter of oxygen through) continuous while on ositive airway					
	"1-17 8am96 12NO2 con't (3L/NC1-16 9p	ogress Notes" stated, 5% on 3L/NC1-17 continued) @ (at) omO2 is continuous @ 2 10pmon O2 3L per					
	practitioner; PA Communication	n, Background, commendation; NP- nurse - Physician Assistant) and Progress Note" dated ed, "increase O2 to					
	1/17/12, indicated distress, 25 sec. apnea, somnoler problem/sympto. The problem/sympto.	and Progress Note" dated ed, "Resp. (respiratory) (second) periods of					

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	OF CORRECTION OF CORRECTION 155784	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 09/2012
	PROVIDER OR SUPPLIER NA HEALTH AND REHABILITATION CENTER	1420 E	NDDRESS, CITY, STATE, ZIP CO DOUGLAS RD WAKA, IN 46545	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	DiminishedO2 at 3 L/min (per minute)To ER for evaluationReported to: Name Dr. (Name) MD Date 1/17/12 Time 7:30 pm"				
	The "SBAR Physician/NP/PA Communication and Progress Note" dated 2/6/12, indicated, "O2 at 2 L/min"				
	The "Vital Signs- Individual Resident Flowsheet" indicated, "1-16 8am3L/NC1-17 8am3L/NC1-17 7pmR/A (room air)				
	The "Respiratory: Plan of Care" last updated on 1/23/12 indicated, "Need for oxygen therapy as orderedBipap, C-pap (continuous positive airway pressure) per physician order"				
	During an observation and interview on 2/6/12 beginning at 3:25 p.m. the DON (Director of Nursing) indicated that Resident #43's biox was 70% and he was being sent to the hospital. Resident #43 observed laying in the bed without oxygen, the oxygen running at 4L next to him and the nasal canula was observed under the foot of the bed. At 3:45 p.m. EMS arrive and inquire how many liters of oxygen Resident #43 was currently on. LPN#1 indicated, "3 liters," EMS place a nasal canula on Resident #43 running at 3L.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 02/09 /	ETED	
		155704	B. WIN		DDDEGG CITY CTATE 7ID CODE	02/03/	2012
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			NAKA, IN 46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		TAG	,		DATE
	During an interv	iew with the DON on					
		m. she indicated she put					
	_	when she assessed him					
	but was unsure of						
		δ.					
	During an interv	iew on 2/6/12 at 5:35					
	p.m. LPN#1 indi	icated, "he's on 2 liters					
	because his CO2	(carbon dioxide) will go					
	up"						
	Surveyor: Manuwal, Vicki						
	2. The clinical r	ecord for Resident # 26					
	reviewed on 2/7/	12 at 11:05 A.M.,					
		ses of, but not limited to:					
		ngestive heart failure, and					
	diabetes mellitus	5.					
	Review of a Phy	sician Order dated					
	-	ed, "Metoprolol Succ ER					
	(extended release	, .					
	1	ve 1 tablet orally once a					
	1 -	**hold for SBP (systolic					
	· · ·	< (less than) 110 or Pulse					
		(blood pressure)/Pulse q					
		Hold Metoprolol (blood					
	1 *	tion) (sic) & Diovan					
		medication) for SBP <					
	_	0Diovan 320 mggive					
	i tablet orally or	nce a day8:00 A.M"					
	Review of the 1/	20/12 through 1/31/12					
	,	on Administration					
	Record) indicate	d the following blood					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	î î	(X3) DATE SURVEY COMPLETED		
		155784	A. BUILDING B. WING		— 02/0	02/09/2012	
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			1420 E	ADDRESS, CITY, STATE, ZIP C DOUGLAS RD WAKA, IN 46545	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	(X5) COMPLETION DATE		
	Pulse 71. The Mometoprolol and I 1/26/12 8 A.MPulse 77. The Mometoprolol and I 1/28/12 8 A.MPulse 92. The Mometoprolol and I I Review of a "Ca Plan of Care" da "HTN (hyperter (treatment) as or protocol" The clinical reconstituting why the doses were held. During interview at 12:45 P.M., should be a proportion of the readings. This Federal Tag 12/12/2011. The	with LPN # 2, on 2/9/12 ne indicated it is unclear nedications would have above blood pressure g was cited on a facility failed to temic plan of correction					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COM	COMPLETED	
		155784	B. WING	ADDRESS SERV. ST. T. T.		09/2012
	ROVIDER OR SUPPLIEF A HEALTH AND R	REHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CO DOUGLAS RD WAKA, IN 46545	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE

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		155784	B. WING		02/09/2012
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			1420	ET ADDRESS, CITY, STATE, ZIP CODE E DOUGLAS RD HAWAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=D	483.25(k) TREATMENT/C The facility must receive proper to following special Injections; Parenteral and experience of Colostomy, uret Tracheostomy of Tracheal suction Respiratory care Foot care; and Prostheses. Based on observation record review, the resident's ox ordered by the paractice affected oxygen in a same Findings included 1. A clinical recompleted for R at 3:25 p.m. Resinclude, but were (Chronic Obstrude) Disease), hypox (hypertension). The MAR (Med Record) for February Care for Febr	ARE FOR SPECIAL NEEDS to ensure that residents reatment and care for the I services: enteral fluids; erostomy, or ileostomy care; are; are; are; are; are administered as the facility failed to ensure ygen was administered as the facility failed to ensure yet yet yet yet yet yet yet yet yet ye	F0328	It is the practice of this faci that the services provided arranged by the facility are proivded by quailifed person in accordance with each resident's written care plant CORRECTIVE ACTION: Results 43's oxygen is being administer physician's order. Results receiving medication per physician's order. HOW OTH IDENTIFIED: Audit of all resident's with orders for Oxyto ensure that physician's order being followed related to rate flow. MAR's audited to ensure that documentation related the are not given have proper documentation an administer per parameters as applicable PREVENTATIVE MEASURE Directed In-service of all nurs staff on Policy and Procedum Medication Administration and following Physican Orders will be completed. DON/Designee complete documented monit	lity 02/29/2012 or onses# stered 226 is lER //gen der is e of ure nat red e. ES: sing e on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155784	B. WIN			02/09/2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER	MISHAWAKA, IN 46545				
(X4) ID	(VA) ID GUNDALD V CTATEMENT OF DEFICIENCIES						
PREFIX				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
1710	REGUERTORTOR	ESC IDENTIFICATION ORGANIZATION		mo	for residents with orders for	DATE	
		37			Oxygen to ensure that the rate	of	
		ogress Notes" stated,	flow is per physician's order and				
	"1-17 8am96	% on 3L/NC1-17			MAR's will be monitored to		
	12NO2 con't (c	continued) @ (at)			ensure proper docuemnttion a	s	
	3L/NC1-16 9p	mO2 is continuous @			well as following paramters for		
	3L/NC1-10-12	10pmon O2 3L per			physician ordered medications		
	NC"				MONITORING: DON and/or		
					designee will monitor Oxygen		
	The "SBAR Phy	sician/NID/DA			delivery and MAR's daily for 2 weeks, then 3 times per week	for	
	1				4 weeks, then weekly for 16		
	(SBAR-Situation				weeks, then monthly for 2		
		commendation; NP- nurse			months.March 12, 2012		
	_	Physician Assistant)			Addendum: All residents with		
	Communication	and Progress Note" dated			oxygen will be monitored by th		
	1/11/12, indicated, "increase O2 to 6L/maskHospitalization" The "SBAR Physician/NP/PA				DON or designee and will cove	er	
					all shifts. The MAR's will be	lulo .	
					monitored per the same sched as the Oxygen. Results will be		
					forwarded to facility Quality	,	
	1	and Progress Note" dated			Assurance for further review a	nd	
		_			recomedations as deemed		
		d, "Resp. (respiratory)			appropriate. Indentified		
		(second) periods of			non-compliance will result in 1	:1	
	apnea, somnolen				re-education with progressive		
	problem/sympton	m started around 6 p.m.			disciplinary actions per policy u	nb	
	The problem/syn	nptom has gotten worse			to and including termination.		
	(circled word)l	Resp rate 24 Lung Sounds					
	DiminishedO2						
		for evaluationReported					
	·	•					
	to: Name Dr. (Name) MD Date 1/17/12						
	Time 7:30 pm" The "SBAR Physician/NP/PA						
Communication and Progress Note" dated		•					
	2/6/12, indicated, "O2 at 2 L/min"						
	The "Vital Signs- Individual Resident						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPL 02/09 /	ETED	
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	Flowsheet" indic 8am3L/NC1- 7pmR/A (room	17 8am3L/NC1-17					
	updated on 1/23/oxygen therapy a	r: Plan of Care" last 12 indicated, "Need for as orderedBipap, C-pap tive airway pressure) per					
	2/6/12 beginning (Director of Nurs Resident #43's bit being sent to the observed laying oxygen, the oxyghim and the nasa under the foot of EMS arrive and of oxygen Reside LPN#1 indicated	vation and interview on at 3:25 p.m. the DON sing) indicated that ox was 70% and he was hospital. Resident #43 in the bed without gen running at 4L next to 1 canula was observed the bed. At 3:45 p.m. nquire how many liters ent #43 was currently on. , "3 liters," EMS ula on Resident #43					
	2/6/12 at 5:08 p.1	new with the DON on me she indicated she put when she assessed him are of the setting.					
	p.m. LPN#1 indi	new on 2/6/12 at 5:35 cated, "he's on 2 liters (carbon dioxide) will go					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155784	B. WIN	G		02/09/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
			1420 E DOUGLAS RD				
MICHIANA HEALTH AND REHABILITATION CENTER				MISHA	WAKA, IN 46545		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE
	Surveyor: Manu						
		record for Resident # 26					
		/12 at 11:05 A.M.,					
		ses of, but not limited to:					
	. –	ngestive heart failure, and					
	diabetes mellitus	5.					
	Davious of a Di	raining Order dated					
	1	rsician Order dated					
	(extended releas	ed, "Metoprolol Succ ER					
	`	ve 1 tablet orally once a					
		•					
	1 -	**hold for SBP (systolic					
		< (less than) 110 or Pulse					
		P (blood pressure)/Pulse q					
	l ` • ′	Hold Metoprolol (blood					
		tion) (sic) & Diovan					
		medication) for SBP <					
		0Diovan 320 mggive					
	1 tablet orally once a day8:00 A.M"						
	Danie - Cal - 1	/20/12 4hman -1: 1/21/12					
		/20/12 through 1/31/12					
	` `	on Administration					
	·	ed the following blood					
	pressure results:						
	1/22/12 8 A.MBlood Pressure 111/77. The MAR indicated the metoprolol and Diovan were both held. 1/26/12 8 A.MBlood Pressure 115/57. The MAR indicated the metoprolol and Diovan were both held.						
		Blood Pressure 111/63.					
	The MAR indicated the metoprolol and						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUILDING B. WING	COMPLETED 02/09/2012				
NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	Plan of Care" dated "HTN (hypertens (treatment) as orde protocol" The clinical record indicating why the doses were held. During interview w at 12:45 P.M., she to her why the med	ovascular/Circulatory: 11/20/12, indicated, ion)Meds/Tx redVital signs per					

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